STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366127	A. Building B. Wing	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlands Health and Rehab Center	6831 North Chestnut Street Ravenna, OH 44266

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility did not ensure Foley catheter drainage bags were covered in a dignified manner. This affected one (Resident #66) out of three residents reviewed for dignity and had the potential to affect two additional (Residents #29 and #38) identified by the facility as having a Foley catheter. The facility census was 77. Findings include: Review of the medical record for Resident #66 revealed an admission date of 06/18/22. Diagnoses included irregular heartbeat, retention of urine, heart failure, high blood pressure and kidney disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #66 was cognitively intact. He was independent for eating, required setup help for oral and personal hygiene and was dependent upon staff for toileting, showering and dressing. Review of the care plan dated 05/14/25 revealed Resident #66 required an indwelling urinary (Foley) catheter. Interventions included measuring intake and output, keeping the tubing and parts of the drainage system off the floor, storing the collection bag inside a protective dignity pouch and avoiding lying on top of the tubing. Observation and interview on 06/23/25 at 9:55 A.M. with Resident #66 revealed he did have a Foley catheter in use. No privacy cover was observed on his catheter drainage bag. Interview at the time of the observation with Certified Nurse Aide (CNA) #201 confirmed catheter drainage bags should be covered with a privacy bag, and Resident #66 did not have a privacy bag on his catheter drainage bag. Review of the undated facility policy Resident Rights revealed the resident had the right to be treated at all times with courtesy, respect, and full recognition of dignity and individuality. This deficiency is an incidental finding identified during the complaint investigation.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to make the appropriate notifications when Resident #79 removed his Foley catheter. This affected one (Resident #79) of three reviewed for dignity concerns. The facility census was 77. Findings include: Review of the medical record for Resident #79 revealed an admission date of 05/01/25 and a discharge date of 05/21/25. Diagnoses included dementia, failure to thrive, repeated falls, diabetes and prostate cancer. Review of the comprehensive Minimum [NAME] Set (MDS) assessment dated [DATE] revealed Resident #79 was severely cognitively impaired. He required supervision for eating, oral and personal hygiene and substantial or maximum assistance for toileting and showering. Review of the physician's orders for May 2025 revealed Resident #79 had an order to change his indwelling urinary (Foley) catheter once a day and as needed. Review of the care plan dated 05/05/25 revealed Resident #79 had an indwelling urinary catheter. Interventions included freedom from infection and urethral trauma, measuring intake and output, avoiding the tubing or any part of the drainage system from touching the floor, storing the collection bag inside a protective dignity pouch and avoiding obstructions in the drainage. Review of the nursing note dated 05/16/25 at 2:33 A.M. revealed Registered Nurse (RN) #207 was walking down the hallway when she noticed Resident #79 standing in his room. Upon entering the room, she noticed blood on the floor and the resident's Foley catheter was not in place. The Foley was noted to be intact with the balloon intact as well. The resident was assisted with a shower, and the Foley catheter was reinserted with no complaints of pain from the resident. Interview on 06/24/25 at 6:40 A.M. with RN #207 confirmed she walked by Resident #79's room and noticed he was standing near his roommate's bed with some blood on the floor. She revealed his Foley catheter had been removed, she assisted him in getting a shower and replaced the Foley catheter. She confirmed she did not notify the residents physician or family of the incident, and this was typically something that should be done when such an incident occurred. Review of the facility policy titled Resident Change in Condition Policy, dated 06/27/24, revealed a significant change of condition was a decline in a resident's status that would not normally resolve itself without intervention by staff, impacts more than one area of the resident's health status and or requires review or revision to the care plan. The physician and family or responsible party would be notified in the event of an accident or injury revolving the resident, the discovery of an injury, reaction to medication or treatment, a significant change to the residents of physical, emotional or mental condition or need to alter the resident's medical treatment including a change in provider orders. This deficiency represents noncompliance investigated under Complaint Number OH00166245.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, self-reported incident (SRI) review, interview and facility policy review, the facility failed to ensure misappropriation of medications for Resident #80. This affected one (Resident #80) of three reviewed for abuse and had the potential to affect all 77 residents residing in the facility. Findings include: Review of the medical record for Resident #80 revealed an admission date of 04/26/25 and a discharge date of 05/31/25. Diagnoses included hypertension, right femur fracture, repeated falls, diabetes, difficulty walking and need for assistance with personal care. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #80 was cognitively intact. She was independent for eating, required supervision for oral hygiene, partial to moderate assistance for personal hygiene and was totally dependent on staff for toileting and showering. She had major surgery to repair her leg. Review of the physician's orders for April 2025 revealed an order for Tramadol (an opioid pain reliever) 50 milligrams (mg) every six hours as needed (prn). Review of the care plan dated 04/29/25 revealed Resident #80 had complaints of pain due to a right femur fracture. Interventions included assessing the effects of pain on the resident, evaluating the effectiveness and pain management interventions, eliminating environmental stimuli, administering medications and monitoring the effectiveness, and positioning for comfort with physical support as necessary. Review of SRI tracking number 259767 dated 04/27/25 revealed Registered Nurse (RN) #200 received a phone call on 04/27/25 at approximately 7:30 P.M. from RN #207 who reported the facility count sheet was off by one pill of Tramadol for Resident #80. RN #207 revealed she questioned the nurse who was finishing her shift, RN #209, about the missing Tramadol and was told she pulled the medication but it was too soon to administer it therefore, she put it in her pocket and when it was time to administer the medication she could not find it. Shortly after that time, RN #209 was asked to assist an unidentified certified nurse aide (CNA) in providing care to another resident. When she returned to the medication cart, she reported she had found the missing Tramadol for Resident #80 and had disposed of it appropriately. By the time RN #200 arrived at the facility to investigate and question RN #209, RN #209 had clocked out and left the facility. RN #200 reached out to RN #209 via text message and asked her to return to the facility to discuss the incident. RN #209 replied she would not be returning to the facility and had terminated her employment. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility investigation, dated 04/27/25, revealed the investigation included resident assessments, resident interviews, staff interviews, medical record reviews, narcotic record reviews, and staff drug screen reviews. RN #209 refused to cooperate with the investigation, and the incident was reported to the Ohio Board of Nursing. The investigation included a search of the facility sharps containers, where RN #209 reportedly discarded the Tramadol, and no discarded medication was located. Resident #80 was interviewed as part of the investigation and her electronic medical record was reviewed. A head-to-toe assessment was completed to include a pain assessment, and no negative effects to Resident #80 were noted. The allegation of misappropriation of narcotic medications was inconclusive. Interview on 06/24/25 at 11:41 A.M. with the Administrator confirmed Resident #80's medication had been misappropriated. Review of the facility policy titled Ohio Resident Abuse Policy, dated 07/11/24, revealed the facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. The definition of misappropriation is the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. The facility will not employ or otherwise engage individuals who have been found guilty of abuse, neglect, or mistreatment of resident by a court of law; had a finding of abuse, neglect, mistreatment, exploitation, involuntary seclusion and/or misappropriation of property reported into a state nurse aide registry, or had a disciplinary action taken against a professional license by a state licensure body as a result of a finding of abuse, neglect, or mistreatment of residents or a finding of misappropriation of property. The deficient practice was corrected on 05/02/25 when the facility implemented the following corrective actions: • Resident #80 was assessed for pain and reported none at the time of the interview. • Nurses on duty at the time of the incident were asked to submit a urine test for drug screening. • On 04/28/25 an e-mail was sent to Pharmacist #210 informing her of the discrepancy and requesting a pharmacy representative to conduct a comprehensive narcotic audit of the facility. • RN #200 conducted an audit of each medication cart as well as the narcotic count sheets and no other discrepancies were noted. • (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	One 05/02/25, a quality assurance and performance improvement (QAPI) meeting was held with the medical director present to discuss the incident. • The former Director of Nursing (DON) and RN #202 conducted audits of the narcotic accountability records, concluding on 04/28/25. • Residents who received narcotic medications were interviewed by the former DON and none reported concerns with receiving medications. • All nursing staff were re-educated by RN #202 regarding medication administration and documentation, concluding on 04/30/25. • Ongoing compliance with medication administration and documentation was conducted for four nurses per week for four weeks. Results were submitted to the QAPI committee for further review and recommendations. • RN #200 conducted weekly audits of as needed narcotic administration records ensuring all doses were signed and documented in the electronic medical record for four weeks. The results of the audits were submitted to the QAPI committee for further review and recommendations. This deficiency is an incidental finding identified during the complaint investigation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, self-reported incident (SRI) review, facility investigation review, interview and facility policy review, the facility failed to ensure residents were free from potential abuse by failing to immediately suspend a staff member after an allegation of staff-to-resident abuse. This affected one (Resident #63) of three residents reviewed for abuse and had the potential to affect all 77 residents in the facility. Findings include: Review of the medical record for Resident #63 revealed an admission date of 03/21/23. Diagnoses included a history of stroke affecting the left, dominant side, hypertension, chronic kidney disease, glaucoma, left eye blindness, osteoarthritis, diabetes and dementia. Review of the quarterly Minimum Data Set (MDS) assessment data 05/06/25 revealed Resident #63 was severely cognitively impaired. He required setup help for eating, partial to moderate assistance for oral hygiene, substantial to maximal assistance for personal hygiene and was dependent on staff for toileting, showering and dressing. Review of the facility SRI tracking number 258295 revealed on 03/15/25 at 11:10 A.M., Housekeeper #214 reported she witnessed Certified Nurse Aide (CNA) #213 physically abused resident #63. Review of the facility investigation revealed Housekeeper #214 witnessed Resident #63 telling CNA #213 he did not want deodorant on. CNA #213 forcefully took his arm and put the deodorant on anyway. Resident #63 called CNA #213 a derogatory name and swatted her away. She revealed she witnessed CNA #213 spray Resident #63 in the face with deodorant and immediately went to the nurse to report her findings. The investigation further revealed Licensed Practical Nurse (LPN) #215 continued passing medications for approximately five to ten minutes prior to addressing Housekeeper #214's concern. CNA #213 reported Resident #63 had been agitated with care and did not want CNA #213 to apply deodorant to his right arm; therefore, she respected the resident's wishes and left his room. She denied forcing the resident to use deodorant or spraying him in the face intentionally. The Administrator spoke with LPN #215 at approximately 5:30 P.M. and was told Housekeeper #214 saw CNA #213 spray Resident #63 in the face with deodorant. LPN #215 confirmed she did not immediately assess Resident #63 and waited approximately ten minutes to do so. At the time of the assessment, the resident did not look like he was in distress, nor did there appear to be any injury to his eyes. The former Director of Nursing (DON) was called at 12:41 P.M. and instructed LPN #215 to switch CNA #213's assignment. The former DON did not suspend CNA #213 upon learning of the alleged abuse. LPN #215 was suspended at 6:45 P.M. Housekeeper #214 was suspended at 6:55 P.M. for not immediately ensuring the resident's safety. The investigation included resident assessments, resident interviews, staff interviews and medical record reviews. Resident #63 was interviewed and assessed as part of the investigation, and his electronic medical record was reviewed. A head-to-toe assessment was completed, and no negative effects to the resident were noted. The allegation of abuse was unsubstantiated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 03/19/25 revealed Resident #63 was resistive to care. Interventions included stopping and reapproaching later, maintaining a calm environment and approach to the resident, allowing the resident to choose options and actively involving the resident in his care. Resident #63 also had a self-care performance deficit. Interventions included encouraging the resident to participate in oral hygiene, only using roll on deodorant and monitoring for pain or intolerance training self-care. Interview on 06/24/25 at 11:41 A.M. with the Administrator revealed CNA #213 was suspended on 03/15/25 at 5:34 P.M. He confirmed she should have been suspended immediately upon learning of the suspected allegation of abuse. Review of the facility policy titled Ohio Resident Abuse Policy, dated 07/11/24, revealed the facility would not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. If abuse was suspected, staff would immediately report the concern to their direct supervisor and not leave the resident unattended unless it was necessary to summon assistance. If a staff member was suspected of abuse, neglect, mistreatment, exploitation, involuntary seclusion and/or misappropriation of property, the facility would immediately remove the staff member from the resident care areas and that staff would remain under direct supervision until a written statement was complete or law enforcement arrived, if applicable. The accused staff member would be removed from the facility and schedule pending the outcome of the investigation. The deficient practice was corrected on 03/16/25 when the facility implemented the following corrective actions: • Upon discovery on 03/15/25, CNA #213, former DON, Housekeeper #214, and LPN #215 were suspended by the Administrator. • Resident #63 was assessed head-to-toe by a licensed nurse. • Resident #63's physician and family were notified of the incident. • An SRI was reported (there was a delay in the EIDC system working). • The Administrator began interviewing the staff in question. • Resident #63 was assessed for psychosocial decline, none noted. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	• All staff were educated on the abuse policy by 03/16/25 by the Administrator or designee. • The SRI investigation was completed by the Administrator and the acting DON on 03/18/25 with no negative findings. • The Administrator worked with Corporate Human Resources and provided one on one education and discipline, if applicable, CNA #213, former DON, Housekeeper #214 , and LPN #215 • To monitor and maintain ongoing compliance, the Administrator or designee will monitor for any accusations or signs and symptoms of abuse to determine if the facility followed the abuse policy three times a week for four weeks and then monthly times two months. • The results of the audits will be forwarded to the facility quality assurance and performance improvement (QAPI) committee for further review and recommendations. This deficiency is an incidental finding identified during the complaint investigation.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and facility policy review, the facility failed to ensure fall interventions were in place and falls were thoroughly investigated. This affected two (Residents #40 and #66) of three residents reviewed for falls. The facility census was 77. Findings include: 1. Review of the medical record for Resident #40 revealed an admission date of 08/08/23. Diagnoses included hypertension, dementia, muscle weakness, chronic obstructive pulmonary disease (COPD) and epilepsy. Review of the fall risk assessment dated [DATE] revealed Resident #40 was a high risk for falls. Review of the care plan dated 02/20/24 revealed Resident #40 was at risk for falls. Interventions included placing the bed against the wall, ensuring the area was free of clutter, ensuring she was wearing proper footwear, and showing her glasses were being used, ensuring common items were within reach and her call light was within reach. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 was cognitively intact. She required set up and clean up help for eating and oral hygiene, substantial or maximum assistance for personal hygiene and was dependent on staff for toileting, showering and dressing. Review of the nursing note dated 06/16/25 at 3:05 A.M. revealed Resident #40 was found in her bedroom on the floor. Resident #40 was complaining of back, neck, head and pelvic pain. Vital signs were obtained while emergency medical transportation (EMT) services were called. Vital signs were within normal limits. Resident #40 had some confusion and delayed response, she could not confirm if she hit her head. She also could not explain how she rolled out of bed and onto the floor. The right-side handrail was noted to be up on the bed. The nurse asked if she was trying to sit up on the bed to which she replied, yes. EMTs arrived and the resident was taken to the local emergency department for examination, the doctor, nurse on call on, the administrator and family were notified. Review of the facility fall investigation dated 06/16/25 revealed Resident #40 rolled out of bed and complained of back, head, neck and pelvic pain. Resident #40 was not wearing footwear at the time of the fall. Vitals signs were blood pressure 120/87, pulse 72, temperature 96.5 degrees and respirations 18. Resident #40 reported a pain level of five on one to 10 scale, 10 being the worst. The investigation did not reveal any evidence if Resident #40's bed was against the wall, if her call light was in reach, or if the area was free of clutter. Interview on 06/23/25 at 3:05 P.M. with Certified Nurse Aide (CNA) #206 revealed she heard yelling from Resident #40's room and when she went to check on her, she was on the floor. She revealed she had just helped change the resident approximately 15 minutes before the fall, but she could not confirm if the residents' call light was in reach at the time of the fall, she reported Resident #40 had been more confused prior to the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of hospital discharge paperwork dated 06/16/25 revealed no negative findings on the CT scans or X-rays for Resident #40; she was discharged home. 2. Review of the medical record for Resident #66 revealed an admission date of 06/18/22. Diagnoses included irregular heartbeat, retention of urine, heart failure, high blood pressure and kidney disease. Review of the fall risk assessment dated [DATE] revealed Resident #66 was a moderate risk for falls. Review of the quarterly MDS assessment dated [DATE] revealed Resident #66 was cognitively intact. He was independent for eating, required setup help for oral and personal hygiene and was dependent on staff for toileting, showering and dressing. Review of the care plan dated 04/04/24 revealed Resident #66 was at risk for falls. Interventions included nonskid strips at bedside, toileting assistance as needed, ensuring his reaching device (a long-handled assistive device to help grasp, pick-up, or retrieve objects) was in use, ensuring the floor was clear of glare, liquids and foreign objects and proper, well-maintained footwear. Review of the physician's orders for 05/21/25 revealed an order to encourage Resident #66 to use his reacher when picking up items, nonskid strips to the bedside and bathroom floor and a Call, Don't Fall sign. Observation and interview on 06/23/25 at 2:33 P.M. with Resident #66 revealed he had a reacher, but it was at home. A reaching device was observed in front of the residents' television, at the end of the resident's bed, against the wall. Interview with CNA #201 confirmed the reacher was nowhere near Resident #66 and should be near him to help prevent the risk of falls. Review of the facility policy titled Fall Prevention and Management Policy, dated 08/06/24, revealed a fall was defined as unintentionally coming to rest on the ground, floor or other lower level. Fall risk assessments would be completed at admission, quarterly and as needed, and individualized interventions would be implemented based on those assessments and care planned accordingly. This deficiency represents noncompliance investigated under Complaint Number OH00166245.